

FILED NOV 10 1943

Registration District No. 53

Primary Registration District No. 3010

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Francis Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 3 da. years, months or days)

3. (a) PRINT FULL NAME EMMA JANE SMITH

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Arion 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 1 1873
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 28 If less than one day hr. _____ min. _____

9. Birthplace Lyons Co. Ky (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Richard Johnson

13. Birthplace Ky (City, town, or county) (State or foreign country)

14. Maiden name Mattie unk.

15. Birthplace unk. (City, town, or county) (State or foreign country)

16. (a) Informant Joe Smith

(b) Address Detroit Mich

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-43 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Sikeston Mo

18. (a) Signature of funeral director Walsh Funeral Home

(b) Address Sikeston Mo

19. (a) 11-3-43 (Date received local registrar) (b) F. D. Phelps (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott
(c) City or town Sikeston (If outside city or town limits, write "RURAL")
(d) Street No. 406 Fletcher St (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 29 year 43 hour 7 minute 55 A.M.

21. I hereby certify that I attended the deceased from 10/27 19 43, to 10/29 19 43 that I last saw her alive on 10/28 19 43 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy Duration _____

Due to _____

Due to _____

Other conditions None (Include pregnancy within 3 months of death)

Major findings: Of operations g3a

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]
Address [Signature] Date signed 10/29/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

JUL 25 1944

RECEIVED

District Health Officer No. 4
District File Number 1143-292
Date Filed 11-8-43

AUG 3 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Raymond Crews*

Licensed Embalmer No. 3467

P. O. Address. *Sikeston Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.